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ABSTRACT

The purpose of this project was to develop a culturally relevant collaborative model focussing on early screening and intervention for Navajo children prenatal exposure to alcohol. A review of the long-term consequences of maternal drinking is presented, and prevalence statistics for American Indian groups are reviewed. Collaboration between a school district and a university made it possible to develop an assessment instrument (Navajo Family Interview), to identify and test children at academic risk and children with prenatal alcohol exposure, and to make recommendations regarding early screening and intervention. Data were collected from students, parents, teachers, counselors, a school psychologist and school administrators. In the first phase of the project, the Navajo Family Interview was administered. The second phase included testing of the child. Eight children with significant fetal alcohol exposure were identified; they were not however diagnosed with fetal alcohol syndrome. They were compared with matched controls. Differences between alcohol affected children and control group are discussed. Guidelines for culturally specific intervention programs are suggested. A chart is included with the plan for collaboration among parents, schools, and community dealing with alcohol-affected children. (Contains 14 references.) (EMK)

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Developing Collaboration Among Parents, Schools and Community to Provide Early Screening and Intervention for Children Prenatally Exposed to Alcohol

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Abstract

The purpose of our project was to develop a culturally-relevant collaborative model focusing on early screening and intervention of Navajo children prenatal exposure to alcohol. This was a joint project between Gallup McKinley County School District (GMCS) and Western New Mexico Gallup Graduate Studies Center (WNMU, GGSC), both contributing funds for this research project. This data includes, but not limited to, the student, parents, teachers, counselors, school psychologist, and administrators. The project included (a) development and use of the Navajo Family Instrument, (b) testing and identification of children at academic risk and children prenatally exposed to alcohol and, (c) recommendations for early screening and intervention.

Introduction

Because of dramatic, long-term consequences of maternal drinking, there is a critical need for further studies of children who exhibit characteristics of fetal alcoholism syndrome (FAS). FAS investigators conclude that there is a continuum of physical abnormalities and behavioral difficulties (Aase, 1994 Streissguth, 1994; Phelps & Grabowski 1994). Criteria for FAS was first published by Jones and Smith (1973) to identify patterns of problems in three main areas:

- Characteristics of abnormal craniofacial features.
- Prenatal and/or post natal growth retardation (below the 10th percentile when corrected for gestational age.)
- Deficient central nervous system impairment including cognitive impairment and developmental delay.

The criteria for fetal alcohol effects (FAE) was also established when only one or two, but not all of the above indicators are present (Aase, Jones & Clarren, 1995).

Based on the above criteria, studies show the prevalence of FAS and FAE among American-Indian groups has been reported as disproportionately higher than other ethnic groups. In the United States, prevalence of FAS is estimated to be one in 500 to 600 live births, and FAE one in every 300 to 350 live births (Burgess and Streissguth, 1992). The overall Southwest American-Indian rate is estimated to be 4.2 per 1,000 when compared to 2.2 for U.S. overall (May, 1994). The highest incidence of FAS/FAE combined births have been reported among the Southwestern Plains Tribes at 20.5 per 1,000 births (May, 1993). The Navajo Tribe,

while lower than Southwestern Plains Tribes is still increasing at alarming rates of 4.7 per 1,000 live births, especially in certain areas of the reservation (Navajo Area, IHS, 1990-94). In Chinle, rates are 1 per 151 live births; Fort Defiance, 1 per 123 live births; Gallup, 1 per 135 live births; and Tuba City, 1 per 250 live births.

Investigators suggest that complex cultural, social and environmental factors are interrelated to produce higher FAS/FAE rates in the Navajo Tribe. Specific cultural drinking patterns and less social integration are related to higher rates of FAS (May, 1994). May and Masis (1991) suggest that chaotic family systems often increase the degree of culture conflict and isolation from the community and increase FAS/FAE rates. Fewer Navajo women drink than in the larger U.S. population but more Navajo women abuse alcohol when they drink. They conclude that "abusive drinking" is concentrated in a minority of families with multiple problems and the development of multifaceted, multidisciplinary programs for FAS/FAE children is necessary to address these needs.

The Navajo Tribe represents the largest American Indian Tribe in the United States with a population of 224,728 (Navajo Area Indian Health Service, 1990) on a reservation which encompasses Utah, New Mexico, and Arizona. The breakdown of the population is as follows: (a) 173,352 live on the reservation, (b) 25,108 live near the Navajo Nation, and (c) 26,268 live elsewhere. Thus, the Navajo Tribe represents an extremely large southwestern rural population with few mental health resources.

With growing numbers of children prenatal exposure to drugs and alcohol, many children with a continuum of FAS/FAE symptoms are struggling in classrooms ill-equipped to address the growing population. There is a critical need for more prevention/intervention programs for both women of childbearing age who are drinking and children with effects of FAS/FAE.

The purpose of this project was to develop a collaborative model focusing on early screening and intervention of Navajo children prenatal exposure to alcohol. This was a joint project between Gallup McKinley County School District (GMCS) and Western New Mexico Gallup Graduate Studies Center (WNMU, GGSC), both contributing funds for this research project. This data includes, but not limited to, the student, parents, teachers, counselors, school psychologist, and administrators. The project included (a) development and use of the Navajo Family Instrument, (b) testing and identification of children at academic risk and children prenatal alcohol exposure and, (c) recommendations for early screening and intervention.

Overview of Research Project Findings

The study was completed in two phases. In the first phase, the Navajo Family Interview (NFI) was administered with special permission from the mother, or primary caretaker. In the second phase the children were screened with the child, including Oral Language Scale (OLS), Peabody Picture Vocabulary Test (PPVT), and Visual Motor Integration Test (VMI). The questions included sections on preferred language used in the family, general family data, and questions about parental observations of the child's

behavior. Mothers were also asked questions about drinking patterns during the pregnancy. From the interview, eight children were identified as having a positive history of prenatal alcohol exposure. They were not diagnosed as having Fetal Alcohol Syndrome (FAS). Alcohol-affected children were matched with control group of 18 children. Control group of children were matched for socioeconomic background, Navajo background, age and grade level and were given the same assessments. Overall results suggested that the alcohol-affected group had lower scores than control group on all tests. There was a significant difference between alcohol-affected group and control group on the Visual Motor Test ($t = 3.29$, $p < .01$). Alcohol-affected children had marked deficits in visual motor performance (Jordan & Tempest, 1997).

Caregivers were asked about preferred language, general family life, and behavioral comments about the children. All children were still living at home with at least one of the natural parents and four children were living with both natural parents and extended family members. Alcohol-affected children came from families with external resources less available and basic utilities such as running water. They were evaluated as having limited English proficiency and spoke both English and Navajo in the home. In addition, all eight children were reported to have moderate to severe behavioral difficulties. Caregivers reported behavioral problems that fit into three following patterns: (a) oppositional behavior (stubbornness, defiance and tantrums; (b)

difficulty tolerating frustration (overly sensitive, reactive); and (c) exhibited attention difficulties.

Recommendations for Interactive Collaboration

Based upon experience with the children in this study and combined clinical experience with children affected by maternal drinking, early intervention programs are vitally important. Streissguth (1994) states that FAS case-finding and screening programs serve both to prevent FAS and to increase community awareness, (p. 72.) Culturally-specific FAS intervention programs are needed to evaluate the relationship of prenatal alcohol exposure and identification of child's strengths and weaknesses. Culturally-specific collaboration includes community ownership and the following providers:

- Mother and caretaker involved with initial screening biological mother's prenatal history including maternal drinking. Include a health screening of other important health concerns.

- School has a district-wide plan for psychoeducational screening that includes appropriate tests, diagnostic services and alternatives in place to best meet educational and behavioral needs of the individual child. Includes a referral for medical dysmorphology evaluation when indicated.

- Mother and caretaker preferred language determined by the school practitioner. Language proficiency and native language of the child is determined.

- Community Cultural Advocate who is an interface between family and school. Cultural advocate helps with translation when necessary and strategies that fit family cultural contexts

and that are rich in local traditions and community-relevant teaching approaches.

Summary

It is very difficult to establish the degree of maternal drinking and the impact of maternal drinking on children. In addition, it is often painful for mothers to accurately disclose a drinking history and deal with the accompanying guilt and denial. The diagnosis for FAS and FAE is difficult to establish because few medical and psychological resources are available to provide services, especially in a rural community. Furthermore, no one specialized test establishes FAS/FAE diagnosis and FAS/FAE children who do not exhibit the common physical anomalies often overlooked. This is certainly true in Gallup and on the Navajo Reservation where the communities are rural, isolated and underserved in basic medical care. Often became of guilt and hopelessness, we lose touch with our existing resources and the strengths of the families and the child with FAS/FAE.

Many Navajo children with FAS/FAE are not diagnosed until they are much older, under-achieving and exhibiting extreme behavioral difficulties. Precious time is lost when alcohol-affected children are not provided intensive educational and counseling services dealing with developmental delays, language deficits and behavioral difficulties.

As concerned educational professionals, we must encourage early intervention and collaborative efforts that focus on the positive strengths of each child identified with FAS/FAE risk

factors. Specific risk factors and stressful life events can be transcended by an optimistic outlook that encompasses overall assets of individual children.

Figure 1. Collaboration Among Parents, Schools and Community Dealing with Alcohol-Affected Children

Participants	Role of Participants	Resources Needed
Parents/Caretakers	• Fill out interview form that includes general family data, biological mother's drinking history, other health concerns, preferred language of family. • Behavioral observations and involved with functional assessment. • Part of the support team that develops therapeutic plan for child.	• Comprehensive Interview Form filled out when child enters school. • Assistance in completing the functional assessment and behavioral observations. • Assistance and training in understanding the various therapeutic options available.
School District Personnel	• Develop a district wide policy and resource center for FAS/FAE children. • Accept referrals on suspected children. • Psychoeducational testing that includes psychological, achievement, adaptive, behavioral data. • Referral to dysmorphologist and/or discussion with family doctor. • Develop a therapeutic plan for each child that includes information from all school personnel involved, parents, cultural advocate and medical community.	• Approved district wide plan and policy in place approved by the local school board. • Resource center available with materials and trainers assisting teachers, parents and the community in teaching and supporting the child with FAS/FAE. • Appropriate assessment tools identified in the native language of the child. • Psychologists, teachers that have native or near-native proficiency in the primary language of the child. • Encourage parent and community involvement in the therapeutic plan and advisory committees dealing with FAS/FAE issues.
Community Cultural Advocate(s) Community Representatives	• Provide support and advocacy for child and family. • Provide interpretation in native language and explanation of technical terms and options available. • Community representatives that can provide needed social services, legal, mental health and other services needed for the child .	• Identification of Cultural Advocates that are available to the school on an as needed basis. • Compilation of local resources available for the child with FAS/FAE and his/her families. • Local community advisory boards and/or task forces suggesting improvements in school /community programs.

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